

LATEX ALLERGY: YES or NO ~ If yes: Airborne or Touch

ALLERGIES TO MEDICATIONS \_\_\_\_\_

Do you take aspirin or any blood thinner YES NO

Briefly describe your chief complaint \_\_\_\_\_

**Medical History**

	yes	no
diabetes	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
sleep apnea (c-pap)	<input type="checkbox"/>	<input type="checkbox"/>
seizures	<input type="checkbox"/>	<input type="checkbox"/>
pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>
tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
emphysema	<input type="checkbox"/>	<input type="checkbox"/>
kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
liver disease	<input type="checkbox"/>	<input type="checkbox"/>
stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
arthritis	<input type="checkbox"/>	<input type="checkbox"/>
gout	<input type="checkbox"/>	<input type="checkbox"/>
anemia	<input type="checkbox"/>	<input type="checkbox"/>
phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
cancer	<input type="checkbox"/>	<input type="checkbox"/>
site _____		
HIV	<input type="checkbox"/>	<input type="checkbox"/>

**Surgical History**

	yes	no
gallbladder	<input type="checkbox"/>	<input type="checkbox"/>
appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
hernia repair	<input type="checkbox"/>	<input type="checkbox"/>
hemorrhoidectomy	<input type="checkbox"/>	<input type="checkbox"/>
colon surgery	<input type="checkbox"/>	<input type="checkbox"/>
orthopedic surgery	<input type="checkbox"/>	<input type="checkbox"/>

If yes, body part \_\_\_\_\_

Titanium or Metal

Other surgery \_\_\_\_\_

Any other information you feel may be important to the doctor \_\_\_\_\_

**Family History**

	yes	no
diabetes	<input type="checkbox"/>	<input type="checkbox"/>
heart disease	<input type="checkbox"/>	<input type="checkbox"/>
colon cancer	<input type="checkbox"/>	<input type="checkbox"/>
ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>
breast cancer	<input type="checkbox"/>	<input type="checkbox"/>

**Social History**

	yes	no	If yes, amount
cigarette smoking	<input type="checkbox"/>	<input type="checkbox"/>	_____
cigar or pipe smoking	<input type="checkbox"/>	<input type="checkbox"/>	_____
alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Breast Patiens please answer the following:**

Date of last menstrual period \_\_\_\_\_  
 Date of last breast exam by a physician \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_  
 Age of first menstrual period \_\_\_\_\_

	yes	no
Personal history of breast cancer	<input type="checkbox"/>	<input type="checkbox"/>
Family history of breast cancer	<input type="checkbox"/>	<input type="checkbox"/>
Previous breast surgery:	<input type="checkbox"/>	<input type="checkbox"/>
biopsy/lumpectomy	<input type="checkbox"/>	<input type="checkbox"/>
mastectomy	<input type="checkbox"/>	<input type="checkbox"/>
implants	<input type="checkbox"/>	<input type="checkbox"/>
other	<input type="checkbox"/>	<input type="checkbox"/>

**Cardiac History**

	yes	no	year
surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	_____
stents	<input type="checkbox"/>	<input type="checkbox"/>	_____
heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
heart valve disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____
stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Please check yes or no for each of the following:**

	yes	no		yes	no		yes	no
weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	indigestion	<input type="checkbox"/>	<input type="checkbox"/>
headaches	<input type="checkbox"/>	<input type="checkbox"/>	chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	gas/bloating	<input type="checkbox"/>	<input type="checkbox"/>
nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	jaundice	<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
neck pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>
chest pain	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
palpitations	<input type="checkbox"/>	<input type="checkbox"/>	blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	black/tarry stool	<input type="checkbox"/>	<input type="checkbox"/>
back pains	<input type="checkbox"/>	<input type="checkbox"/>	difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	bloody stools	<input type="checkbox"/>	<input type="checkbox"/>

**Contact in case of emergency (someone not residing with you):**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_